South East **LHIN**

Better Integration, Better Health Care

South East Local Health Integration Network
Integrated Health Services Plan 2013-16

Ontario
Local Health Integration Network

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Please note that the appendices referred to in this document are available online at, www.southeastlhin.on.ca in English only.

PREFACE

This is a document written for the people who live in southeastern Ontario, outlining a plan that will have a significant impact on their health care system in the years to come. It is a plan that depends for its success on the extraordinary commitment and skill of the health care providers in this region, and we require their help with its implementation. We also look to the Ministry of Health and Long-Term Care (MOHLTC) for its support over the next three years as we put in place a plan that will improve patient outcomes, as well as health system sustainability, in South East Ontario.

EXECUTIVE SUMMARY

This is the third Integrated Health Services Plan (IHSP(3)) to be released by the South East LHIN. The IHSP is our way of keeping Ontarians, the health care providers in our region, and the provincial government, informed about our plans for managing and funding health care in South East Ontario. This IHSP, which we have called *Better Integration, Better Health Care*, builds on the foundation of our first two IHSP's, identifies our priorities for the coming three years, and outlines the various programs and initiatives that will help us achieve those priorities. It is a plan that will help us improve access to high level care for the people of this region, by creating regional systems of integrated care.

These systems will better meet the needs of a changing patient population, one that is more typically frail and living with multiple chronic conditions.

This IHSP is being released at a time when there are significant transformational pressures on our health care system. These pressures include the current economic climate, the limited availability of resources, the aging of our population and the steadily rising cost of delivering health care. Clearly, change is required if the health care system on which we depend is to be sustained.

In creating this plan, we were guided by existing provincial priorities, including those outlined in Ontario's *Action Plan for Health Care* released in January 2012. We were also guided by extensive engagement and consultation about the needs and priorities of the patients and providers in this region. Additionally, we were guided by research on the state of health care in South East Ontario today and the directions in which the system is moving.

As the name implies, *Better Integration, Better Health Care* is a plan to integrate the components of the health system in south east Ontario. We are not proposing to do this in a vacuum. Health systems everywhere, and certainly here in Ontario, are moving towards increased integration. There is widespread agreement that the best and most sustainable health care systems are those that have not only accepted, but actively embraced, the concept of integration.

An integrated health care system is one that reduces overdependence on acute hospital care by increasing the quality and availability of care in the community. This kind of "upstream" work gives people the support and tools they need to stay healthy at home, resulting in fewer trips to hospital and lower overall costs to the system. An integrated system is one in which providers work together right across the system, with the patient as their absolute focus, meaning that nobody falls through the cracks and everyone receives the care they need, when and where they need it.

Within the overall context of integration, *Better Integration, Better Health Care* establishes three key priorities for the direction in which we plan to take health care in south east Ontario over the next three years:

1. Developing a regional system of integrated health care across the care continuum, from primary care and public health through to community, acute and long-term care

2. Improving the patient experience with a focus on the transition points in care

3. Focusing on the unique health care needs of Aboriginal and Francophone populations

We will achieve these priorities by working closely with providers in this region on the delivery of a number of programs and initiatives.

Developing a regional system of integrated health care across the care continuum, from primary care and public health through to community, acute and long-term care

Working towards this first priority will involve a number of high-level initiatives in several areas that will help us improve system integration. These include:

Health Links

The plan is to create seven health care "clusters", with different provider groups joining forces within these clusters. They will share information, pool resources, and work together to achieve the best possible health outcomes for patients.

Strong Hospitals

The focus on community services in this IHSP will help reduce the burden on our hospitals, freeing them up to deliver the kind of acute care only they can. Through our Clinical Services Roadmap and regional capacity planning, this IHSP will directly improve hospital care, and access to that care, within this region.

Community Support and Community Mental Health and Addictions Services

Helping people to remain healthy in their homes and communities is a big focus of this IHSP. To do this, we must build stronger networks of community support along with the mental health and addictions services that provide the care and the setting patients need to help avoid repeated visits to hospital emergency departments.

Information System and Enabling Technologies

There is increasing focus across the continuum of health care on better electronic management, storage, sharing and use of information in order to improve access and health outcomes for patients.

Improving the patient experience with a focus on the transition points in care

Transition points in health care are those points at which patients either move from one provider to another or one setting (such as acute) to another (such as community). It is at these points that the system sometimes allows patients to fall through the cracks. Over the next three years, we are going to work to change that aspect of health care, as well as to improve the overall experience of being a patient within the South East health care system.

Better Care for Seniors

Many seniors are coping with multiple health issues that require frequent and varied types of health care to manage. Our plan for the next three years is to help seniors stay healthy longer, so they can remain at home and in their communities as long as possible.

Mental Health and Addictions

Our plan calls for us to, in cooperation with providers and other health care partners, redesign mental health and addiction services in the South East across all levels of care. We need to ensure that patients dealing with these serious health problems are given the priority and care they need.

Chronic Disease Management

Chronic diseases can often be very successfully managed if patients are able to take part in that management by improving their health behaviours. This IHSP will ensure that providers and patients have the tools they need to ensure their diseases are managed in the best way possible.

Palliative Care

Palliative care is one of the most delicate, complex, and important forms of health care imaginable. The province has established a vision for palliative care that says:

> *Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death, to help them live as they choose, and optimize their quality of life, comfort, dignity and security.*

The South East LHIN shares in that vision and is aligning itself with the province in order to help make it a reality.

Focusing on the unique health care needs of Aboriginal and Francophone populations

Ontario's Aboriginal and Francophone populations have health care needs that are unique and separate from those of most people in the province. This IHSP calls for us to work with providers and our Aboriginal and Francophone communities to ensure that everyone in our LHIN can count on receiving health care that is accessible and culturally appropriate.

Aboriginal Health Care

The Aboriginal and Metis populations in our LHIN face a number of cultural and socio-economic challenges that affect their health care and shape their health service needs. We will spend the next three years working directly with their leaders to identify the best ways of helping them overcome these challenges and meet the unique needs and priorities of their communities.

Francophone Health Care

We have a clear obligation to ensure that language is not a barrier for Francophones in our LHIN who seek access to health care.

Together, the South East and Champlain Local Health Integration Networks and the Réseau des Services de Santé en Français de l'Est de l'Ontario (the planning entity for French-language health services) have created a Joint Annual Action Plan (JAAP) that identifies objectives and joint actions that will promote improvement and efficiency in the delivery of high quality French-language health services.

Over the next three years, we will work with the Réseau to update, refine and implement this plan.

In Summary

We are confident the South East LHIN's IHSP3 builds upon the lessons learned and the gains made through our two previous IHSPs. It also sets out a clear path for the way ahead – a path that may present us with challenges, diversions and alternate routes – but that, ultimately, will help us reach our destination as we strive to provide all residents of the South East region with improved access to the quality care they deserve.

INTRODUCTION

Local Health Integration Networks were created in 2005 with a mandate reflected in their names – Local Health Integration. We know that for health care systems to be truly effective, they must be managed to reflect local needs and priorities. For this to happen, there must be better integration amongst health provider organizations and across health care sectors. LHINs were created to do just that.

Ontario's LHINs are responsible for the allocation of about half of the province's health care expenditures, or about $22 billion in funding as of 2011. Working with the Ministry of Health and Long-Term care (MOHLTC), LHINs help ensure that local and regional plans align with provincial priorities for the health care system. The main goals are to improve access to care and ensure sustainability.

The South East LHIN

The South East LHIN covers 19,473 square kilometres and is the largest rural health region in Southern Ontario. It receives four percent of the total funding to all LHINs, for a total budget of $ 1.1 Billion (estimated as of December, 2012). This is distributed amongst 91 health service providers delivering approximately 120 programs and services to the region's 492,000 inhabitants.

This Integrated Health Services Plan, entitled *Better Integration, Better Health Care*, is a three-year strategic plan for local health care in the South East.

The *Local Health System Integration Act, 2006* requires each of Ontario's 14 LHINs to develop and publish their own individual regional plans. This IHSP is the South East LHIN's third and covers the years 2013-2014 through 2015-2016.

The IHSP establishes three strategic priorities for our LHIN:

1. Developing a regional system of integrated health care across the care continuum, from primary care and public health through to community, acute and long-term care

2. Improving the patient experience with a focus on the transition points in care

3. Focusing on the unique health care needs of Aboriginal and Francophone populations

Building on the solid foundation laid with the first two IHSPs, and on the progress they achieved, *Better Integration, Better Health Care* reflects many of the same values and goals of those first two plans, but it also presents a clear new chapter in the health care story that is being written not only in South East Ontario but right across this province.

A CHANGING LANDSCAPE

In the three years since we presented our second IHSP, the economic picture in this province, and in the world around us, has changed dramatically. Ontario suffered through a recession that forced everyone in health care to take a fresh look at an old problem: how, with a population that is growing and aging, do we deal with the twin threats of rising costs and increasingly limited resources?

As with most jurisdictions around the world, Ontario is looking for new and better ways of delivering the health care services its citizens need.

In the wake of the recession, Canada's economic recovery is expected to be slow. In step with this, Ontario is grappling with a significant deficit while the demand for health care services continues to grow. Today, the province is spending 42 cents of every dollar on health care. If current patterns persist, it is estimated that within 12 years health care spending could consume 70 cents of every dollar. Clearly, ways must be found to deliver services more cost-effectively – a challenge that health care and economic experts have begun to address.

Alternate Level of Care (ALC) days refer to days spent by patients in hospital when they should be receiving more appropriate care in the community or at home. ALC is a serious issue in most jurisdictions and a drain on hospital resources. Dr. David Walker, Ontario's provincial ALC Lead produced a report in 2011 in which he makes several suggestions for improving the situation facing ALC patients waiting for discharge from hospital. The report concludes that the health care system needs to undergo a broad transformation in order to meet the care needs of an aging population. Additionally, in 2012, economist Don Drummond released a wide-ranging report on reforming Ontario's public services that included several cost-cutting health care measures.

Against this backdrop, the Ontario government devised a strategy to transform the health care system. In June of 2010, the *Excellent Care for All Act* was signed into law. This legislation focuses on ensuring quality and value in health care. It paved the way for a new funding formula that is clearly linked to the delivery of better care to patients. This new performance-based system includes tying executive compensation to the achievement of previously established quality improvement goals. The *Excellent Care for All Act* also created a new agency, Health Quality Ontario, whose mandate is to recommend evidence-based standards of care, support health care providers in adopting these

standards, and monitor and report on quality improvement efforts across the province.

Prior to the election in 2011, the LHIN Leadership Council (made up of LHIN CEO's) advised the Health Minister and Mr. Drummond that improved access to high quality care could be achieved within a 2% growth in the health care system and for this to be achieved primary care needed to be a part of the LHIN mandate.

The Ontario government then released the *Action Plan for Health Care* in early 2012. The plan, which builds on the foundation laid by the *Excellent Care for All Act*, is designed to create a health care system that delivers high-quality services at the best possible price, and delivers on the province's vision for health care. That vision, as articulated by former Minister of Health and Long-Term Care The Honourable George Smitherman in 2004, is "a health-care system that helps people stay healthy, delivers good care to them when they need it, and will be there for their children and grandchildren."

Better Integration, Better Health Care reflects that need for integration. It was informed by the work of experts like Walker and Drummond, and is very much in line with the *Action Plan for Health Care*. It is designed to deliver the South East LHIN vision, which is "achieving better health through proactive, integrated and responsive health care in partnership with an informed community."

THE INTEGRATION IMPERATIVE

It is rare these days to hear a conversation about what needs to be done in health care that does not touch on the idea of integration. When LHINs were created six years ago, with "integration" worked into their names, the notion was already well established in health care circles but not well understood outside them. It is likely better understood today, but there remains a sense that it is a bit of a catch-all term for the various things that need to be done to transform health care.

To properly understand what we mean by integration, it is important to take into account the changing expectations we have of our health care system. There was a time when the strength of the system was judged almost exclusively by the number of hospital beds, doctors and nurses. Strengthening the system was understood to mean increasing those numbers. Clearly, doctors, nurses and beds remain critical, but the real strength of our system going forward will lie in its ability to reduce the need for them. A system that is too focused on providing acute hospital care and treating disease is inefficient and unsustainable. What is needed, instead, is a system that prevents serious illness and reduces the need for hospitalization and lessens the duration of long-term stay. Only an integrated health care system can do that, while remaining financially strong and effective.

An integrated health care system is able to do the kind of upstream work that helps people avoid the need for a trip to the hospital. It is a system that gives people the support, tools and knowledge to stay healthy at home. If they do get sick or injured, it is a system that provides them with the care they need in their communities. This eases the strain on hospitals by removing the burden of being the first point of contact in situations that could, and should, be handled in the community.

An integrated health care system ensures that as patients navigate the transition points from provider to provider and service to service, they never fall through the cracks and they always receive the care they need, when they need it. In situations where hospital care really is required, an integrated health care system ensures that patients are treated in a timely fashion and that their discharge back into the community is coordinated and managed with their best interests in mind.

In an integrated health care system, care providers ranging from doctors and nurses to pharmacists, personal care workers and physiotherapists work together, sharing knowledge and exchanging ideas, with the common goal of helping their patients. This results in better care. It reduces duplication and increases efficiency. Finally, it ensures the sustainability of the system, ensuring that it will indeed be there for our children and grandchildren.

Integrated Health Services Plan 2 (2009-2012)

As noted earlier, this plan builds on the successes achieved and lessons learned in the two previous IHSPs. In fact, *Better Integration, Better Health Care* flows seamlessly out of its predecessor, *Reaching for Excellence*, to the point where that IHSP must really be seen to be a part of this new plan. This is because all of the good work that began in *Reaching for Excellence* will be leveraged and continued in *Better Integration, Better Health Care*. Our approach may be different. We have narrowed our list of priorities. Everything we do will be viewed through a more sharply focused integration lens. But any success we enjoy in this third IHSP will have been made possible by the work that came before.

Reaching for Excellence – Notable Accomplishments

- Establishment of a Primary Health Care Lead
- Signing of the Memorandum Supporting Collaboration between the LHIN and 10 of 14 Family Health Teams (FHTs) and Family Health Organizations (FHOs) in the region
- Approval and development of health care 'Links'
- Signing of an accountability agreement with the Reseau as the SE LHIN's planning entity for French Language Services
- Hiring of a second Aboriginal Nurse Practitioner to deliver quality services to the Aboriginal population
- Completion of a survey of the Metis population
- Completion of all implementation readiness activities for diabetes management
- Completion of standard data sets and forms for resource matching and referral, leading to the ability to standardize the way clinicians refer patients between Hospitals in the SE LHIN region.
- Creation and adoption of a Clinical Services Roadmap for key hospital and CCAC services
- Creation and adoption of a regional surgical charter that defines how hospitals will work together to deliver surgical services
- Integration of administration support services for community providers enabling more money for direct client care
- Development and launch of a request for qualification for non-urgent patient transport – a necessary first step towards a regional approach to patient transportation
- Support for the "repatriation" of mental health services from the Champlain LHIN to the Brockville General Hospital
- Support for the transfer of inpatient mental health services from Hotel Dieu to the Kingston General Hospital
- Significant reduction of wait times for cataracts, MRIs, hip/knee replacements

FRAMEWORK FOR PLANNING

This plan is a logical continuation of its predecessors but it is also very much a product of its time, and a response to the needs of this time and of the three years to come. In creating this plan, we were:

- Guided by extensive engagement and consultation
- Informed by careful analysis of current health status and services, as well as projections about the future
- Driven by the current priorities of the MOHLTC, which all LHINs are mandated to pursue

For more information on the LHIN's planning framework please refer to appendix A.

LHIN 2012/2013 System Imperative Framework

In January 2012 the province unveiled Ontario's *Action Plan for Health Care*, which is intended to meet the challenge of managing spending growth while continuing to provide high-quality care to all Ontarians.

The Action Plan identifies three focus areas:

1. Keeping Ontario Healthy
2. Faster Access and a Stronger Link to Family Health Care
3. Right care, Right time, Right place

The goal of the Action Plan is to create an "obsessively patient-centred" health care system by ensuring care is based on evidence, care is delivered in the right setting and care is coordinated so that patients move from one provider to another seamlessly.

To align the high-level goals of the *Action Plan* with their IHSPs, Ontario's LHINs have developed several system imperatives. These imperatives will guide decisions LHINs make regarding the allocation of resources among providers and the programs and projects to be funded at the local level. Ongoing accountability will be tracked through strategic planning, accountability agreements and performance measurement. The four imperatives are:

1. Leading with Quality & Safety by focusing on establishing coordinated safety practices that ensure patients are safe and that adverse events are minimized or eliminated;

2. Enhancing Access to Primary Care by advancing strategies to ensure people have timely access to a primary care provider;

3. Enhancing Coordination & Transitions of Care for Targeted Populations by ensuring that our most vulnerable patients are able to receive the care they need, when and where they need it, and that their transitions from acute care back into the community are smooth and coordinated;

4. Holding the Gains is a fourth imperative to ensure that new initiatives will not cause previous improvements in care to be eroded.

IHSP3 Engagement and Consultation

LHINs were created to manage and fund health care at the local level. Our job is to understand the health care needs and priorities of our communities, and to manage the system in such a way as to reflect those priorities and ensure that those needs are met. It would not be possible to do this without engaging extensively with our communities.

Community engagement is one of the South East LHIN's foundations for excellence. It is also a point of pride. We don't engage and consult because we are required to do so by law. We do it because it's the right thing to do. *Better Integration, Better Health Care* is a plan that will have a significant impact on the health care system on which the people of the South East LHIN depend. It is a plan for them, and because of the extent to which we consulted with them in shaping it, it is also a plan by them.

Our five-pronged engagement and consultation approach included:

- Broad public engagement through the use of a dedicated website and a detailed online workbook. This provided background and context on IHSP3, and asked people for reaction and comment on those healthcare issues that matter most to them. We received responses from nearly six hundred residents across the region

- Reaching out to local business leaders, through a series of presentations to regional Chambers of Commerce and Rotary Clubs

- Unique populations engagement, whereby we sought input from French-speaking residents and members of the Indigenous Council on their particular healthcare needs

- Meetings and discussion sessions with health providers, including OMA physician members across this region

- An Expert Reference Panel was developed to provide guidance. Members included Economist Don Drummond, Dr. Duncan Sinclair, Dr. Heather Stuart and Dr. David Walker. The Panel met with us on three separate occasions to provide input on our proposed IHSP strategy and to give us their feedback on an early draft of the IHSP3

Additional details of the South East LHIN engagement and consultation are captured in appendix B.

Engagement and Consultation

What was surprising about our engagement process was that there were no surprises. Members of the public told us much the same thing that our providers and experts told us. This is just some of what we heard:

- Prevention, chronic disease management and end-of-life care are considered to be priority areas by residents of the South East – followed closely by mental health, information sharing, system sustainability and caring for an aging population.
- People want easier access to their medical information – and they want their care-givers to have it too – in order to smooth out their journey through the healthcare system.
- Most people prefer to receive specialized follow-up treatment at a larger hospital in a city than at a smaller clinic closer to home.
- Rather than having to wonder what treatment steps are next, or having to "hound" for updates, patients want direct, follow-up contact and direction from their caregivers.
- When it comes to managing the health care needs of frequent users of the system, people feel access to a family doctor or nurse practitioner is the most important factor in preventing or reducing the need for repeat visits to hospitals.

Regional Capacity Assessment and Projections (ReCAP)

ReCAP is a systematic analysis of data and demographics that allows us to understand our population, their health status, their habits of living that may impact health and how they use health-care services. Future demand is projected using this current picture and applying expected population growth. It was first used in IHSP2, and was refreshed for this plan. ReCAP provides us with an advanced analysis of current and projected demand for health care in the South East LHIN. Detailed information on the analysis is provided in appendix C.

ReCAP provides an analysis of:

- Where we are now
- Where we are going if the population demand for health care grows and nothing changes in the delivery of service
- What the impact will be on health-care providers and whether they have the capacity to meet projected need

We were able to use that analysis to identify the emerging themes and challenges outlined below, which in turn informed the development of this plan.

Emerging Themes

As was the case with IHSP2, the ReCAP analysis was critical in shaping our understanding of the health care situation in our LHIN. It paints a picture of health status and service utilization, with gaps that are easy to spot. These gaps will not be easily filled, but thanks to our analysis we know what needs to be done.

An Aging Population

Our LHIN is aging rapidly. The South East LHIN has the highest proportion of seniors in the province. While our overall growth rate is fairly slow (0.5%), there is a significantly higher growth rate in our senior population. The population in the 65-74 year old age group is expected to grow annually by 4.5% while the 75 and over age group is expected to grow annually by 2.1%.

Some regions in the LHIN will in fact experience overall population reduction in the coming years, while at the same time seeing the number of seniors in their areas increase.

The Threat of Chronic Diseases

Generally speaking, people in the South East LHIN exhibit higher rates of high risk behaviours and poorer health status than people in other LHINs. Consequently the burden of disease in the South East LHIN is higher than provincial averages. This is particularly true in the case of major chronic conditions, including circulatory, endocrine, respiratory and digestive system diseases. There is also every reason to believe that as the proportion of seniors in the South East LHIN continues to grow, the burden of chronic diseases will also increase in severity.

The Burden on Hospitals

Residents of the South East LHIN tend to rely more heavily on hospital services than people in other LHINs. The South East LHIN also has high rates of acute inpatient, day surgery, and emergency room use compared to other LHINs. Additionally, hospitals in the South East have higher acute lengths of stay. Our LHIN is also dealing with long ALC stays in hospital,

which may be due in part to the high proportion of seniors in our region and our tendency to use hospitals in the absence of care in the community. While the percentage of acute inpatient days classified as ALC has declined considerably – from approximately 17% of all inpatient days in fiscal 2009/10 to just over 12% in the past fiscal year – there is still much work to be done in improving transitions back to the community.

The rate of use of complex continuing care appears higher than those of other LHINs but the rate of inpatient rehabilitation is very low – almost half the provincial rate among those 75 and older. This may indicate the need for a redistribution of resources to reflect actual usage and need since patients within complex continuing care beds often require only slow stream rehabilitation or convalescent care instead.

The emergency department (ED) length of stay for non-admitted patients has been declining modestly over the past three years but, with an average wait time of approximately 25 hours collectively across the LHIN, much work still needs to be done in order to improve the flow for this patient population. The ED wait for non-admitted patients remains close to the LHIN (and provincial) targets of 6.8 hours for high-acuity (more serious), patients, and 4 hours for low-acuity patients.

Several of the smaller rural hospitals have high percentages of low-acuity ED visits – and a few of the local municipalities have among the highest rates of low-acuity ED visits across all of Southern Ontario. This clear preference for using the hospital for treatment of all types of illness and injury, regardless of whether they're urgent or not, poses a real threat in the form of backlogs, with the overworked hospital spending valuable time on non-acute patients while patients in serious need have to wait.

Provincial Objectives

Better Integration, Better Health Care is a plan designed to shape the delivery of health services in our region, in a manner that reflects the needs and priorities of this region. It is a plan specific to the South East. It is also, however, a plan informed by the provincial priorities outlined in the *Action Plan for Health Care*. In it are seven basic health objectives common to all parts of Ontario that we, our fellow LHINs and the province are working hard to address.

Reducing Wait Times in Emergency Departments

Emergency department wait times have long been a barometer by which people measure the quality of their health care system. There is no time when people want medical attention more than when they or someone they love is waiting for it in a hospital ED. There is broad agreement that the best way to reduce these wait times is to reduce the number of ED visits, and the best way to do that is to offer people alternatives. That means improving performance across the entire health-care system. All LHINs are now working extremely hard to build better health service capacity within their communities, so people in need of non-urgent medical attention can find the care they need without having to visit a hospital.

Achieving Provincial Objectives

The Ministry has set provincial targets for ED wait times, and LHINs are mandated to report their wait times to the public. In addition, the LHIN has set specific targets within each of the hospitals' accountability agreements and is working together with hospitals and the community to continue to improve ED wait times through our efforts in the Clinical Services Roadmap (see appendix D).

Reducing Time in Alternate Level of Care

As noted, ALC occurs when treated patients awaiting discharge encounter delays in finding the services they need in order to return home, or if they have to wait for long-term care placement or rehabilitation beds. Just as the lack of community-based alternatives can cause backlogs in hospital emergency departments, the shortage of appropriate community care alternatives, particularly for seniors, can result in patients spending much more time in the hospital than is desirable. Currently, 15.8% of the patients in South East acute care hospital beds are considered to be ALC, which not only puts patients at risk of deteriorating mobility and exposure to healthcare acquired infection but also puts a strain on our hospitals and costs our health care system a great deal of money.

Reducing ALC days is a major priority in for the Ontario health care system.

Achieving Provincial Objectives

The LHIN has included targets for reduced ALC rates in accountability agreements with all of our health service providers other than LTC homes. Many ongoing initiatives continue to have a positive impact in this area and we will continue to work together to build on these successes:

- Home First, where we are changing the culture of health care to acknowledge the reality that "being at home with support is good for your health"
- Enhanced role of the Community Care Access Centre (CCAC) in managing patient discharge from hospital from the beginning of a patient's stay so the patient, family and care providers in and out of hospital know what to expect
- Enhancing supports available in the community for at risk, elderly patients to continue living where they are comfortable (SMILE, supported congregate living)
- The Clinical Services Roadmap (see appendix D) focuses on restorative (rehabilitative care) for at risk seniors during their stay in hospital, to shorten length of stay and reduce the negative impact on patient health of being in hospital

Senior Friendly Strategy

The MOHLTC is currently developing the next phase of its Seniors Care Strategy helping our seniors get the right care, at the right time and in the right place. The plan will focus on helping seniors stay active, remain healthy and live at home longer. Our LHIN already has a robust plan that focuses on care for seniors, and we will ensure that this plan aligns with the provincial strategy when it is unveiled.

Achieving Provincial Objectives

A robust strategy that helps seniors stay active and healthy so they can live at home longer is a clear provincial priority, and a major focus of this IHSP as well. The South East LHIN better care for seniors plan includes:

- **Senior Friendly Hospitals (page 34)**
- **Rapid Response Nurses (page 35)**
- **Nurse-Led Outreach Teams (page 35)**
- **Falls Prevention program (page 35)**
- **Supported Living (page 36)**

Capacity Planning/Quality Based Procedures

Capacity plans are an increasingly popular alternative to the old system of simply counting the number of patients and beds in order to estimate budget needs. Capacity plans take into account the individual needs of patients and the resulting volume of services that will be necessary to sustain equitable, evidence-based, high-quality care. Capacity plans are a key component of the province's new patient-based, funding system that draws a clear link between high quality, efficient care and sustainability.

The information collected through capacity planning will be used to inform LHIN plans for system change at the local level, specifically as they relate to volume management (where services are provided and in what number) and resource utilization (getting the best value for money). This planning process is intended to create more efficient and effective patient-centred patterns of care and deliver on Ontario's *Action Plan for Health Care*.

Better Chronic Disease Management

Chronic diseases are long-term diseases that develop slowly and often become much more serious. Patients who develop one of these diseases frequently end up suffering from multiple chronic conditions. In Ontario, patients with chronic disease account for 55% of direct and indirect health costs. Chronic diseases are very difficult to cure, but if managed properly their effects can be lessened and controlled. The most common chronic diseases in our LHIN include diabetes, cardiovascular diseases (heart disease and stroke), and diseases related to respiratory and digestive systems.

Chronic disease management is a proactive approach to improving health that involves patients taking an active role in their own care with the help and support of their health care providers. Much of the care in this situation can be done at home and in the community. It has been estimated that Ontario could have saved $220 million in 2010 if all diabetic patients in the province had received chronic disease management. Furthermore, the province would have saved $465 million if all congestive heart failure (CHF) patients in the province had received chronic disease management.

Achieving Provincial Objectives

LHINs are working with partners from across the health care system to implement better Chronic Disease Prevention and Management through the work of the CSR (see appendix D) and the development of Health Links (page 26).

Enhancing Mental Health and Addictions Services

People with mental health issues and addictions are among the most vulnerable people in our society. It has been estimated that 20 percent of Ontarians experience a mental health or addiction problem at one time or another. They must battle not only the illness but the stigma that surrounds it.

Ontario has developed a long-term comprehensive mental health and addictions strategy called *Open Minds, Healthy Minds*, which LHINs will be helping to implement. The plan has four main priorities:

1. Improve mental health and well-being for all Ontarians
2. Create healthy, resilient, inclusive communities
3. Identify and intervene in mental health and addictions problems early
4. Provide timely, high quality, integrated, person-directed health and other human services

Achieving Provincial Objectives

Enhancing mental health and addictions services is, in addition to being a provincial priority, a key focus of this IHSP. We intend to work with our partners to redesign mental health and addiction services in the South East across all levels of care. In addition, we are making the following foundational improvements:

- Better coordinated access (page 37)
- Implementing the Health Services Restructuring Commission Directives (page 37)
- A health human resources plan (page 38)
- An emergency department strategy (page 38)
- Improved regional behavioural support services (page 38)

Information Systems and Enabling Technology

Twenty-first century health care depends on health care information being available electronically and on using technology to help diagnose illness and manage care plans. Paper records are almost a thing of the past. There is increasing focus across the continuum of health care on better electronic management, storage, sharing, and use of information in order to improve access and health outcomes for patients.

Ontario has an information system strategy that is focused, in broad terms, on enabling systems to talk to each other in order to get secure, accurate and comprehensive patient information into the hands of health care providers as quickly as possible. This is being done through the creation of electronic health records (EHRs) for Ontarians, the establishment of electronic medical systems (EMRs) in hospitals and doctors' offices, and the building of platforms like the Ontario Laboratories Information System (OLIS) that enable various systems to communicate and share information. Clearly, the success of this strategy depends on excellent regional integration that allows for the secure and seamless sharing of information, and Ontario LHINs have been charged with working towards this goal.

Achieving Provincial Objectives

Advancing information systems and enabling technology, in addition to being a provincial priority, is a key focus of this IHSP. We will be establishing an effective and comprehensive information management system with a number of initiatives (see appendix E), including:

- A Clinical Document Repository
- eConsultation and eReferral
- A regional collaborative space
- A regional database
- The Base Information Technology Initiative
- A hospital information system

Overview of the South East LHIN 2013-2016 IHSP

Starting with Ontario's Action Plan for Health Care

'Ontario's aging population and fiscal challenges require changes to how we deliver health care. We have an action plan to build a quality system that is more responsive to patients and delivers better value for taxpayers'...Deb Matthews, Ministry of Health and Long Term Care

Action Plan Themes

Keeping Ontario Healthy (Support to become healthier)

Must be a primary goal and requires partnerships to promote healthy behaviours and better manage chronic conditions

Faster Access to Stronger Family Health Care

Creating a robust primary health care system will assist in better access to the right care and help patients navigate the system

Right Care, Right Time, Right Place

Patients will receive timely access and know where to go to get what they need

IHSP – The Plan

- Improve access to a better integrated Primary Health Care System
- Strengthen Community Support and Community Mental Health and Addictions Services
- Improve access to quality mental health and addictions services
- Transition the Chronic Disease Prevention and Management Team

- Improve access to a better integrated Primary Health Care System
- Expand Seniors Care Strategy to incorporate provincial direction
- Support Primary Health Care with better management of chronic conditions

- Support the development of a strong hospital system
- Implement the Clinical Services Roadmap
- Create and implement capacity plans to further high quality care for specific specialized services (i.e. surgery)
- Enhance an effective and comprehensive information management system
- Create and implement a regional palliative care plan
- Support the Aboriginal population to better manage their health concerns
- Improve access to French Language Health Services

BETTER INTEGRATION, BETTER HEALTH CARE – THE PLAN

As mentioned at the outset, three overarching priorities have been established for the South East LHIN IHSP3. These were identified through our extensive community engagement and discussions with health service providers, and informed by our ReCAP analysis. What follows is an explanation of these priorities, and an associated list of initiatives we plan to use in order to achieve them. The appendices accompanying this document provide more detail about many of these initiatives.

It is important to recognize that the specifics of our strategy may change and evolve over the course of the plan's implementation. Good strategic plans always include an element of flexibility. Our three priorities, however, will not change, and regardless of any evolution that may occur with respect to the initiatives we are planning, everything we do over the three years covered by this plan will relate back in some manner to one of more of these priorities.

Priority 1 – Developing a regional system of integrated health care across the care continuum, from primary care and public health through to community, acute and long-term care

The importance of integration cannot be overstated. The quality, and sustainability, of our health care system depends on the cooperation and shared vision of everyone involved in the delivery of health services. Driving integration in everything we do will be a primary focus over the next three years.

Health Links

For much too long, health care in Ontario – and almost everywhere else – has been characterized by a system of near silos. What we mean by this, in the context of primary care, is many different independent primary health care organizations – such as family physicians, family health teams, community health centres and family health organizations – that do great work, but do it in something of a vacuum. Currently, there is very little of what we call horizontal integration amongst these groups, where one organization might have access to the resources or expertise of another in order to help one of its own patients, or where several organizations might work together to develop a region-wide plan for dealing with specific health issues within the LHIN.

There are more than 4000 primary care entities in the province – 374 of them are located in our LHIN. We have several different models, with very little linkage between them. Some offer 24-hour on-call coverage, some do not. Some entities can offer diabetes education, some cannot. This means that some of our patients have better access to primary care than others. The solution, we believe, is the system of patient-focused networks that we are going to spend the next three years building.

The Health Links model of primary health care delivery is the very definition of integration. The plan is to create seven primary care "clusters", with different provider groups joining forces within these clusters. Their mission will be to identify gaps in primary health care and work together to find ways of bridging those gaps. It represents a significant shift in how health care is provided, moving the South East LHIN much closer to the kind of integrated health care delivery that was envisioned when LHINs were created.

Building on progress to date

Much of the foundation for Health Links was laid in early in 2012. The year began with the development and signing of a Memorandum Supporting Collaboration between the LHIN and many Family Health Teams and Family Health Organizations. This was quickly followed by the appointment of a Primary Care Physician LHIN Lead, whose function is to act as a liaison between primary care providers in this region and the LHIN, ensuring that providers have a voice at the decision-making table. Also in 2012, membership in the Primary Health Care Council of South East Ontario was expanded to include

representatives from 15 sub-LHIN regions, as well as representatives from the LHIN, the Primary Care Physician Lead, and various stakeholder organizations. The Primary Health Care Council was created to provide a forum for primary care groups in the LHIN to explore better access and integration of their services and to drive improved quality.

How it Will Work

The introduction of the Primary Care Physician Lead and Primary Health Care Council effectively sowed the seeds of the Health Links within our LHIN. Using factors like geography, patient flow, birth rates and demographic trends, the LHIN determined that the most logical clustering will result in seven of these networks across the LHIN. Membership in a Health Link will be voluntary, and there will be deliberate flexibility as to exactly how the cluster will be governed and run. The networks are not limited to primary health care membership and will include a strong partnership with other providers like local hospitals, the Community Care Access Centre, Community Support Services and Mental Health and Addictions supports. The one consistent requirement will be that members must sign an agreement or memorandum of understanding based on the fact that they will be working together in the best interests of their patients with an initial focus on delivering better outcomes in care delivery and improving the patient experience.

It will be our job to make providers understand that there is no downside to joining a Health Link, and that the upside – both for them and their patients – is considerable.

For example:

- Providers in a Health Link will have access to the expertise and services of other providers. This will allow them to offer better care and a wider range of services to their patients – something that is very important for managing chronic diseases. For example, a provider who does not offer diabetes education would be able to access those services from another provider in the network

- Providers will all have access to network-coordinated quality improvement activities, all resulting in a higher standard of patient care

- There will be an ability to share on-call services with a larger pool of providers, making it easier to offer expanded hours to patients

- There will be opportunities for back-office integration, administrative support and data sharing, so relevant patient information can flow securely and more easily among providers within the Health Link

- Providers in a Health Link will be able to better participate in system planning, working with our LHIN to establish and monitor targets. We, in turn, will be better positioned to help them achieve those targets

It is expected that all Health Links in the LHIN will be established before the end of year two of this IHSP.

Strong Hospitals

It is important to understand that no amount of integrated community care is ever going to eliminate the need for hospitals, and our desire to bring about more integration does not in any way suggest that hospital care has become somehow less important. Ontarians can and should be proud of their hospitals. They are among the best in the world, and in our LHIN we intend to help them get even better.

Clinical Services Roadmap

The Clinical Services Roadmap (CSR) was launched in 2010 to help improve access to some of the most essential hospital services that exist in health care. CSR was designed to cut down on the red tape faced by patients moving from one caregiver to another, and help hospitals and the CCAC better integrate their services to deliver more seamless care in our hospitals and communities. The CSR is an excellent example of the kind of collaboration that leads to better health care. Providers in seven hospitals work with the CCAC, community providers and our LHIN to improve service provision, reduce program duplication, and improve access, efficiency and effectiveness. Over the next three years, we will be fully implementing the CSR in the South East LHIN.

The CSR identifies seven areas of focus, each with its own clinical plan, which over the next few years will be advanced and implemented through various initiatives. A key lever for the CSR will be the accountability agreements between the LHIN and its providers. These agreements reflect performance objectives and targets over a multi-year period. The hospital, CCAC and community provider accountability agreements will incorporate specific expectations with respect to delivering on CSR initiatives specific to each provider.

Clinical Services Roadmap – Seven Areas of Focus

1) Cardiovascular care – Increase focus on chronic heart disease management and a reduction in readmission to hospital following a cardiac incident
2) Emergency Department Wait Times – Find ways to improve processes that will reduce the amount of time people wait to be seen
3) Healthcare Acquired Infections – Reduce the number and severity of infections acquired in health care settings
4) Mental Health & Addiction Services – Ensure patients receive the right care at the right time in the right place, enhance capacity of providers and the system, and reduce stigma
5) Restorative Care – Coordinate care between health care providers and rehabilitation specialists, and better manage continuing chronic care
6) Maternal & High- Risk Newborn Care – Ensure the latest treatments and services are used when caring for high-risk mothers and their babies
7) Surgical Services – Create a regional, collaborative approach to manage effective surgical care across all hospitals and post-surgical care by the CCAC

For more information about the programs and initiatives that will be driving the Clinical Services Roadmap over the next three years, consult appendix D.

Regional Capacity Planning

The current fiscal environment is speeding the arrival of certain inevitable and necessary changes in health care. It only makes sense that hospitals and other care organizations will be better able to provide high quality care with the money available today if they specialize in fewer services rather than trying to be all things to all people all of the time. We will also be working with our hospitals to implement leading practices like short stay units, where patients receive special pre-op support and care in order to shorten the length of time they need to be in hospital, and common intake for surgeries which lets different hospitals work together to help patients get the services they need as quickly as possible.

We will explore moving other services, such as outpatient rehabilitation, palliative care and some mental health services, to the community in order to achieve more value – delivering the same or better quality care with the money we have available, and to do it closer to the patients' homes. To that end, we will also be working closely with the CCAC on improving system navigation and client transitions – all with an eye to delivering the most value for the population served through better integration and better planning.

The important thing to remember about moving some services to the community is that, in addition to delivering equal or better care for less money, we will also be relieving the strain on our hospitals, freeing them up to deliver the kind of acute care services that only they can.

Strengthen Community Support and Community Mental Health and Addictions Services

Much of what we are doing in this IHSP3 involves improving and increasing the care and support that patients receive in the community. To that end, we want to build stronger networks of community support and mental health and addictions services, in order to better support individuals at home longer. Building stronger networks means, in effect, integrating many of these services.

The LHIN has implemented back office projects in finance, human resource management, information technology and common purchasing. This work has increased capacity for many community organizations by allowing them to spend less time on back office administration issues and more time on direct client services. We intend to build on this progress and shift our focus to client services over the next three years.

With a focus on improving equity of access to community care programs, combined with getting the best value for money, we will involve providers and patients in designing a patient-focused system of care. We will redesign community support and mental health and addictions services to make it easier to match the types of services patients need to the providers of those services. A redesigned system will emphasize common processes and a shared information system so there is less need for case management and more ability to provide direct client services. As a result, fewer patients will fall through the cracks as they transition from one provider or resource to another and from one part of the region to another.

Information Systems and Enabling Technologies

Effective and comprehensive information management (IM) is critical to everything we do in health care. Integration requires good IM. The Health Links we are creating will also depend on effective information exchange, as will every initiative we plan to use to improve patient experience and outcomes in the LHIN. This strategy is driven by the clear understanding that electronic information storage, management and sharing is an absolutely integral part of modern health care. The South East LHINs IM strategy is driven by precisely that same understanding and will be developed and delivered in partnership with our fellow LHINs in the northeastern cluster – comprised of the North East, North West and Champlain LHINs.

What follows are just some of the initiatives we are planning over the next three years as we build the information management system we need to help deliver the care our patients need. For more information on these and other initiatives, see appendix E.

Clinical Document Repository
South East and Champlain LHINs are currently collaborating on a project to create a Clinical Document Repository (CDR) for Eastern Ontario. Electronic clinical document repositories store clinical documents from right across the health care system, and make them instantly available to authorized health care providers when and where they need them.

eConsultation & eReferral to Specialists for Primary Care
In January 2010, a pilot project was launched in the Champlain LHIN region to improve patient care by increasing primary care physicians' access to specialists. Under the pilot project, which is called BASE (Building Access to Specialists through E-consultation) participating family physicians submit a consult request to participating specialists through a web-based tool. Depending on the request, the specialist can provide the primary care physician with answers to questions and avoid the need for the patient to see the specialist; request additional information before being able to provide advice; or recommend a formal referral.

Regional Collaboration Space
The South East LHIN will maintain a secure electronic collaboration space, to facilitate more efficient and effective communication and sharing of information amongst healthcare providers across the region.

Creation of a Regional Database System
The establishment of a regional database, using the Ontario health card as an identifier, will allow us to dramatically improve our understanding of where our patients are, and what they need.

Hospital Information System Collaboration
Still in the early stages, this project will be a significant step towards creating an integrated electronic health record for South East Ontario patients. It would improve information flow across the LHIN, improving care and maximizing cost-effectiveness.

Ontario Lab Information System
The Ontario Lab Information System (OLIS) is a centralized repository for the exchange of laboratory results that is being implemented by eHealth Ontario. It will allow authorized practitioners from across the province to order lab tests and view results electronically.

Developing a Regional System of Integrated Care – The story of Jack and Gladys

Blessed with good health throughout their long and happy marriage, Gladys and Jack grew increasingly dismayed as their advancing age brought them into more and more frequent contact with doctors, hospitals and pharmacists.

They couldn't understand why, for example, that when they *did* have to seek care at a nearby clinic or a far-off hospital, it seemed they spent more time reciting the same symptoms and answering the same questions from a dozen different people with clipboards. Didn't *anyone* pay attention?

But with the introduction of new technology like the Clinical Data Repository and the electronic transfer of their medical records and treatment charts that brought all of their caregivers up to speed on how best to treat them, Gladys and Jack found it easier to navigate their way through a system that was becoming more responsive to their needs.

These new technologies have not only enabled caregivers to apply the *precise* treatment their patients need – and, by doing so, reduce the costs of duplicate, inefficient and time-consuming "best-guess" treatments – they have also bolstered Gladys and Jack's confidence that the treatment they're receiving is the best available, which in turn has increased their determination to follow treatment and stay healthy.

As their needs change and they continue to age, Jack and Gladys will receive the kind of support that will keep them independent and healthy for as long as possible. Whether it's access to a nearby Nurse-Led Practitioner Clinic that will help them guard their health and avoid trips to a hospital emergency department; or perhaps their eventual need to rely on their Community Care Access Centre for help with a move to a supported living apartment complex where they can remain active and socialize with neighbours – along the way Jack and Gladys will have access to the right care, in the right place at the right time for as long as they need it.

Priority 2 – Improving the patient experience with a focus on the transition points in care

When we talk about the transition points in health care, we are talking about the points at which patients either move from one provider to another, or one setting (i.e. acute) to another (i.e. community). These are often stressful times, and very often represent critical moments of progress in the patient's health care journey. All too often in our health care system today, they are the points at which patients are most easily overlooked, or forgotten about. Over the next three years, we are going to work to change that aspect of health care, as well as to improve the overall experience of being a patient within the South East health care system.

Better Care for Seniors

It should come as no surprise that seniors are among the highest users of health care. Indeed, seniors account for 47% percent of all health care spending in Ontario. In the South East LHIN, poor health status (high blood pressure, heart disease, arthritis, diabetes, asthma) and risk behaviours (poor diet, smoking and inactivity) are worse than the provincial average for adults 65 years and older. This constitutes yet another reason why it is so important that we find better and more efficient ways to deliver the health care that our seniors require, and that we support them in managing their conditions themselves, in their homes and communities.

Health Links

The implementation of Health Links will support significant improvement in our seniors' care, as it will allow a variety of providers to work together with seniors, to support them to stay healthy and better manage their chronic diseases throughout their lifespan.

Identifying Seniors at Risk

Some seniors who enter the health care system are more at risk than others. We know that the earlier we can identify these vulnerable patients, the better we can do to ensure that they receive the most appropriate care, services and monitoring. Over the next three years, we will be working with hospitals, the Community Care Access Centre (CCAC), Community Support Services and primary care providers to not only do a better job of identifying at-risk seniors, but of alerting the entire system so that they receive the care they need, whether in their community or in the hospital.

Senior Friendly Hospitals

As we get older, we become more vulnerable to the kinds of illnesses and injuries that require hospital care. Unfortunately, not all care provided in hospital settings today consists of the kind of best practices and processes that are tailored specifically for seniors. As a result, seniors occasionally experience adverse events, prolonged hospitalization and a resulting deterioration of physical and cognitive function. One recent survey indicated that 55% of hospitals province-wide aren't providing the best available care processes for seniors. The South East LHIN hospitals will be participating in a provincial program to improve the care that hospitals provide to seniors. There are 16 key processes that will be looked at as part of this initiative, of which two –managing delirium and reducing functional decline – are this LHIN's top priorities.

Rapid Response Nurses

Frail seniors who return home from hospitals after an acute episode may require special attention to ensure their care needs are being met and their health continues to improve outside of the hospital setting. The role of a rapid response nurse is to work to facilitate a timely discharge from the acute care hospital setting by ensuring the appropriate provision of community care. These nurses link with primary care and other allied health providers to support the senior as they recover at home. Over the next three years, we will increase the number of rapid response nurses in our LHIN, which will ensure better care for our seniors and fewer hospital readmissions.

Nurse-Led Outreach Teams

A recurring problem in health care is seniors with relatively minor problems being transferred from their long-term care homes to local emergency departments to receive care that their long-term care home (LTCH) should have been able to provide. Nurse practitioners have been identified as a key resource to assist long term care homes in managing these low-acuity events and improving quality of care in LTCH's. Over the next three years, we will increase the number of Nurse-led Outreach Teams in our LHIN. These teams travel to LTCH's, providing onsite assessment and treatment, education to frontline LTCH staff and conducting family discussions related to advance care planning. These steps result in fewer transfers to the ED.

Behavioural Supports Ontario

Behavioural Supports Ontario (BSO), announced by the Province in 2012, was created to enhance services for elderly people with complex behaviours due to dementia, mental health or other neurological conditions. These behaviours, which occur whether the person is living at home, in acute care or in LTCH, are a major source of distress not only for to the person with the behaviour, but also family, caregivers and others providing support.

BSO will enhance and leverage the existing service system and promote integrated service delivery through interdisciplinary mobile teams based around the region who are able to respond, around the clock, to calls from LTCHs that need this support and expertise.

Over the next three years, we will not only pursue the BSO model in LTCH, but also work with providers and community organizations to expand the model to include primary care, hospitals and other community care providers.

Falls Prevention

It is widely understood that while anyone can slip and fall, the risk of falling becomes greater with age as does the risk of injuries as a result of falling. It has been estimated that every year, one in three Canadian seniors will fall at least once, with hip fractures the most common type of injury that results. Nearly half of all injuries among seniors happen at home, with bathrooms and stairs being the most dangerous areas. Falls cannot always be avoided, but it is possible to support certain kinds of physical and lifestyle changes that will reduce the risks of falling. Over the next three years, we will work with Public Health, the CCAC and our long-term care homes to develop a regional approach to falls prevention that aligns with the provincial Falls Prevention Toolkit.

Seniors Managing Independent Living Easily

We launched our Seniors Managing Independent Living Easily (SMILE) program in 2008. It was designed to make it possible for seniors who are most at risk of premature institutionalization – usually the frail and elderly – to receive help with activities that are essential to daily living, so they can remain in their homes. A key feature of this program is that it is primarily client-directed; seniors identify what they need in order to feel confident about remaining at home. We will continue to invest in this program in the years to come.

Home First

Home First was launched in September 2010, introducing a new way of thinking about seniors' care. It seeks to change the long-established pattern of having older patients either languish in hospital or get placed directly into long-term care after their hospital treatment is done, when in fact with the right supports in place their health care needs could be addressed at home.

With the Home First approach, health care providers in the hospital work together with CCAC case managers and other community partners to explore whatever options might be available to support patients returning home. What we discovered is that very often, simply asking that question leads to answers being found, and more patients are now getting to spend as much time as possible in the comfort and dignity of their own home. Ensuring and enabling patients to return home with appropriate levels of care after their acute care is completed also eases pressures on hospitals and reduces the demand for long-term care beds. The LHIN will continue to promote and support this approach into the years to come.

Supported Living

We have heard often from seniors in our LHIN that they want to stay at home as long as possible and avoid living in institutions. Accordingly, a supportive living model of care has been implemented and is being spread across the LHIN to help make that wish a reality. Supportive living can be applied in individual homes or within a supportive housing complex such as an apartment where a group of seniors are living. These seniors are not necessarily identified as high risk users of the health care system, but would clearly benefit from having quick access to personnel who can provide daily living care, socialization with other seniors during coordinated meet-and-greets, better nutrition through careful food preparation and organized dining, and physical activity thanks to a regularly-provided exercise program.

Benefits of supported living include slowing seniors' physical and intellectual decline, reducing their anxiety and improving their self-esteem. In addition, the number of unnecessary ED visits and applications for long term care placement are reduced. Over the next three years, we will work with the province to explore more ways of supporting seniors in their homes, and to expand the number of supportive housing options in our LHIN.

Mental Health and Addictions

Patients with mental health and addiction (MH&A) problems must not only cope with their conditions, they must also deal with the stigma surrounding them. Physical problems may be dismissed or overlooked by care providers who primarily see the mental health or addiction condition. They may also be ignored by patients who are hesitant to deal with a system that may not have treated them well in the past. This is a situation that has endured for much too long, and in the coming years our LHIN is going to work with our providers to end it in our communities.

We intend to work with our partners to redesign mental health and addiction services in the South East across all levels of care, to ensure that patients dealing with these serious health problems are given the priority and support they need and deserve.

We will better support young people as they transition from children's mental health to the adult mental health system. To begin, in conjunction with providers, the LHIN has completed an analysis of the demand for services and community gaps. We will work with community providers to ensure access to an equitable basket of services.

We will work to ensure that providers have the tools and supports they need to recognize specific issues and conditions for what they are, and the knowledge to properly deal with them. This includes the confidential sharing of relevant patient information amongst providers in the circle of care to improve and enhance assessment, development and delivery of care plans, and reduce the number of times patients must tell their stories.

We will also work with our hospitals and community health organizations to develop appropriate discharge plans, so that when a patient is ready to leave hospital he or she will be going to the right place, and receiving the right care in the right environment. In general, a stronger system of community supports, with better sharing of information, will allow us to support patients elsewhere, instead of just in hospital.

In addition, there are a number of other initiatives under our Clinical Services Roadmap that will help us ensure patients with mental health and addictions problems can receive the care they need. These include:

Coordinated Access

We have heard from our residents and from our providers that the current system is disjointed, confusing and difficult to navigate for patients with mental health and addiction problems.

Over the next three years, we will be improving this situation by requiring providers to use standardized referral forms and assessment tools, the results of which will be shared with other healthcare providers.

Coordinating access across the region ensures that patients do not get lost trying to find the "right" provider and that they only have to tell their story once.

This initiative is intended to improve quality of care through standardization and to make it easier to find and ultimately receive necessary services.

Health Human Resources (HHR) plan

A health human resource plan for mental health and addictions will ensure that our providers can align with the intent of the provincial MH&A strategy. The plan will support quality care and improved access to MH&A services across the continuum of care. This will be accomplished by building the capacity of providers across the continuum in order to ensure they are able to provide the care that is required and appropriate for each setting (whether hospital, community, or primary care).

Emergency Department (ED) MH&A strategy

The intent is to improve service response time and access to care for MH&A patients, as well as for patients who present with challenging behaviours. This strategy will result in reduced reliance of MH&A patients on EDs, and improved care for them in their communities. The plan will include:

- **Better communication between providers**
- **Access to MH&A crisis counsellors in the ED**
- **Closer coordination with community MH&A partners to increase capacity in the community that will support clients outside the hospital setting**
- **Development of a transitional day program to smooth the transition for patients from the hospital setting to more independent living in the community**

Mental Health & Addictions – The story of Jenn

As a child growing up, Jenn encountered challenges in socializing that developed into episodes of behaviour requiring serious attention and care. As she grew into her teens surrounded by the love, support and careful supervision of her family, Jenn received the care and medication she needed to keep her illness under control.

But when these mental health services – available only to children – were due to lapse on Jenn's 18th Birthday, she and her family grew increasingly concerned about how the withdrawl of these supports might affect his chances of becoming a happy, responsible and independent adult.

Thanks to the help of a Transition Facilitator, who helped Jenn and her family understand how the programs and services that were available to her as a child could be adjusted and continued through programs available to adults, Jenn's future became brighter.

Working with Jenn, the Transition Facilitator studied existing services in both the children's and adult systems to assess the types and levels of service that would ensure her long term improvement and access to care.

The facilitator not only acts as a resource to local hospitals, the CCAC, mental health and addictions services providers and their housing and training facilities – she also provides Jenn and her family with the education, assistance and advocacy to make certain that appropriate access to support will always be available.

Making sure that this kind of transition care is available to people with mental illness provides the best hope for patients like Jenn to have as productive and happy a life as possible – while also reducing the burden and costs to the healthcare system that results from frequent crises and trips to the Emergency Department by patients who do not have these supports.

Chronic Disease Management

As noted earlier the South East LHIN has substantially higher prevalence of chronic disease than the rest of the province. This is largely attributable to consistently poor health behaviours. What we know about chronic diseases is that they can be managed, particularly if patients are encouraged to take a hand in that management and improve their health behaviours. A big focus in the coming years is to make sure that providers and patients have the tools they need to ensure that these diseases are managed in the best way possible.

Better Prevention and Self-Management

Enabling patients to manage their chronic diseases at home and in their communities will not only result in better health, it will also ease the strain on our hospitals. To that end, our LHIN will seek out opportunities to work alongside public health to promote healthy behaviour practices in the community. Enabled by Health Links and better information sharing by providers, patients will have access to information and resources to help them manage their diseases. In addition, both providers and patients will have faster access to test results, making the disease easier to manage.

Transition of Diabetes Accountability

In order to strengthen local planning and coordination of care for people living with diabetes, the MOHLTC has increased the mandate of the LHIN to include diabetes planning and coordination of services. This new mandate will enable increased oversight of these programs and will support the integration of the programs with other local services. With local involvement, the LHIN can assist with removal of barriers in order to improve access to resources, such as self-management, health education and disease management tools and processes.

The focus for the first year will be on strengthening and sustaining the effort around diabetes care. The lessons learned will then be applied to the other chronic diseases prevalent in our LHIN, such as congestive heart failure and diseases related to respiratory or digestive systems.

Palliative Care

In 2011, the province issued a review of its palliative care system entitled "*Advancing High Quality, High Value Palliative Care in Ontario – Declaration of Partnership and Commitment to Action.*" It was a collaborative effort by more than 80 stakeholders from across Ontario who brought to the table a wide range of insights and expertise to the table.

The report presented the following vision for palliative care in Ontario:

> *Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death, to help them live as they choose, and optimize their quality of life, comfort, dignity and security.*

We at the South East LHIN share that vision, and over the next three years will align with the province in its attempts to make it a reality.

Advance Care Planning

Advance care planning is the process of deciding on, and informing others about, our future health and personal care preferences in the event that we become incapable of consenting to, or refusing, treatment or other care. One simple example would be a preference to die at home. We will work with providers to establish a framework under which advance care planning can be honoured and respected.

Improve Education of Primary Health Care Providers

End of life care requires providers to understand and take into consideration factors that are not always medical in nature. This is not always easy, and few providers have received any training in this area. We will spend the next few years working with our providers to set up a system under which their staff will receive the education, knowledge and skills they need to provide dying patients and their families with all of the care and support required.

A Sustainable Hospice System

We will focus on building appropriate hospice support in the community. The work has begun on the analysis and development of integration options for community hospice service provision across the LHIN. Once defined, the LHIN will move forward with the development of up to three residential hospice pilot sites in 2013-14 with full evaluation in 2014-15. Based on this evaluation, the LHIN will develop a long term residential hospice plan. Initial pilots will be collaborative with primary care, CCAC, community supports, and hospital partners. We will also explore the potential for overnight respite or transitional use of beds when not occupied by palliative clients.

Transitioning From Hospital to Community Services

As noted above, many patients want the comfort and dignity that comes with being at home in their last days. Over the next three years, we will work with our community health providers to establish in-home care standards for palliative care and over time increase the number of palliative patients who are able to stay at home.

Improving the patient experience with a focus on the transition points in care – The story of Don and Susan

Having lived with diabetes for most of her adult life, Susan traditionally relied on hospital and outpatient care whenever she needed help controlling her disease, dealing with adjustments to her medication or changes in her course of treatment.

But with the increased availability of Primary Health Care, Susan – now in her mid-sixties – has been able to get the education and support she needs right there in her community to learn how to self-manage her diabetes. With the right kind of instruction, and by practicing the right ways of administering her medication under the guidance of a local nurse practitioner – along with the help of a dietitian who gives solid advice on how to choose and prepare the best foods for her condition – Susan has become remarkably independent and has taken charge of her diabetes. She is happier and more determined to protect her health; while her hospital no longer needs to dedicate the time, staff and resources to do for Susan what she is now able to do for herself.

Some years later, when her husband Don is unfortunately diagnosed with a terminal form of cancer, they are able to get the support they need to manage his disease at home. As the end draws near, Don receives palliative care in his home, emotionally comforted by familiar surroundings and the precious visits by family and friends – rather than having to spend his final days adjusting to the rigorous routine and impersonal setting of a hospital ward.

Through it all, Susan and Don have been able to access the kind of care that was right for *them,* while at the same time reducing the burden on the traditional hospital channels they would have had to rely on in the past.

Priority 3 – Focusing on the unique health care needs of Aboriginal and Francophone populations

Ontario's Aboriginal and Francophone populations have health care needs that are unique and separate from those of most people in the province. With respect to Francophones who live in our region, we have an obligation to ensure that language is not a barrier to their access to care, which means providing many of those services in French. The Aboriginal and Metis populations in our LHIN face a number of cultural and socio-economic challenges that affect their health care and shape their health service needs, and we have an obligation to help them overcome those challenges. We are committed to working with providers and our Aboriginal and Francophone populations to ensure that everyone in our LHIN can count on receiving health care that is accessible and culturally appropriate.

Aboriginal Health Care

Build Strong Relationships Through Improved Engagement with Aboriginal Population

The biggest challenge we face when it comes to providing our Aboriginal people with the healthcare services they require is one of communication. We want to spend more time talking with them and listening to them, so that we have a clearer picture of what we must do to meet their needs. Through the use of engagement processes like Visioning Circles, we will work over the next three years to identify the health care needs and priorities of our Aboriginal communities. We will involve Aboriginal and Metis leaders in the planning process. The result will be a plan we have all agreed on – one that will provide better access to services and better health outcomes.

Focus on the Unique Requirements of Aboriginal and Metis Patients

It is not enough to simply say that we are going to expand chronic disease management tools and protocols to Aboriginal patients and their health providers. Clearly, we have to do this, but we also have to work with community leaders to ensure that we are taking into account the specific needs, priorities and culture of these communities. In our consultation with the Mohawks of the Bay of Quinte, for instance, we heard that among their top priorities were mental health and addiction services and supportive living options for seniors. We will be working with that community over the next three years to help meet those priorities. Building on the work already completed with the Metis that identified many health concerns, including chronic disease, the LHIN will work with this group to help them in developing better self-management strategies and tools. We will also work with them to promote healthy behaviours.

Over the next three years, together with our Aboriginal and Metis partners, we are going to identify the many ways in which we can adapt our health care programs and services for these communities so they will do the most good. The LHIN will encourage our providers to participate in cultural sensitivity training to assist them in better understanding the population they serve.

Francophone Health Care

Implementing the Joint Annual Action Plan on French Language Health Care Services

The LHIN is committed to the development of services in French in the South East and particularly in the city of Kingston, the most recently-designated area under the French Language Services Act. Over the next three years, the LHIN will continue to work with health service providers and other francophone partners to involve our Francophone community.

The LHIN will also strengthen ways of considering the francophone view in the development of new projects and initiatives. Also, the LHIN will continue to engage and work with its French Health Planning Entity (the Réseau des Services de Santé en Français de l'Est de l'Ontario) on various matters related to the health of the francophone community, and will look to them for advice and support.

The South East and Champlain LHINs and the Réseau have created a Joint Annual Action Plan (JAAP) that identifies joint objectives and actions to promote continuous quality improvement and efficient delivery of high quality French-language health services. This Plan is to be revised and updated every year. Over the next three years, the LHIN will continue to work with the Réseau to refine and implement these plans.

The Joint Action Plan 2012–2013 includes five objectives:

1) **Improve quality of data for better planning**
2) **Strengthen Francophones' participation in health service planning through community engagement**
3) **Ensure that French-language health service planning meets the needs of the Francophone community**
4) **Improve the active offer of French-language health services**
5) **Measure the impact of our actions on French-language health services**

Implementation of the JAAP will result in improved planning as a result of Francophone involvement, better access to services for Francophone patients, and improved health outcomes for patients as a result of that improved access.

Focusing on the unique healthcare needs of Aboriginal and Francophone populations – The story of Luc

Five-year-old Luc and his parents recently moved to this region of Ontario from their home province of Quebec. Shortly after they settled into their new home Luc needed an operation to remove a benign cyst that had begun growing rather quickly under his tongue.

The procedure went perfectly well, but in the recovery room – still groggy from the anesthetic – Luc called out "Maman....Maman". In hearing his cries, the nurse and doctor assumed the little guy was crying out in pain so they administered an additional dose of pain killers to provide him with relief. They didn't understand that Luc was simply crying out for his mother.

In a sophisticated, multi-cultural society such as Canada, Luc and his family not only deserve to receive their medical care in the language of their choice – they also deserve care that doesn't carry the potential to endanger them if their caregivers misunderstand what's wrong with them or what they need.

With this in mind, the South East LHIN has been working with the French Language Entity to help health care providers acquire the ability to treat Francophone residents of our region in their chosen language. It goes beyond courtesy. It responds to what can often turn out to be a medical necessity when the rapport between a caregiver and a patient is critical to ensuring that diagnoses and treatment are crystal clear, and that treatment is appropriate and correct.

Similarly, our healthcare system is honour-bound to ensure that Aboriginal residents of this region are treated in a way that respects their culture and traditions – again, not only out of courtesy – but because we must create and sustain an environment of trust and comfort in which their special needs can be accommodated to ensure they receive the health care they deserve.

MEASURING SUCCESS

It has been said many times that you can't manage what you can't measure, and this is as true in health care as it is anywhere else. Many good plans have been developed, only to be abandoned or fade away because no mechanism was put in place to measure their progress and success. We will not let that happen with this plan. We are increasing the likelihood of delivering on this plan for our region by building in a focus on measuring and reporting on progress. This will be a challenge given the silo'd system we have today and our difficulty in tracking patients/clients along their health care journey. It must also be remembered that three years is not a long time in health care, and it will certainly take longer than that for real progress to be made in certain areas.

That said, we are going to be working hard to answer the following critical questions:

1) **Have we shown demonstrable progress in achieving our desired end state vision as described by the three strategic priorities?**
2) **With respect to any initiatives we have identified, what progress has been made with respect to implementation?**
3) **Is there broad utilization of the new systems and processes?**
4) **Are we delivering the expected benefits?**

We have also established a few overarching indicators that we consider indicators of success (or failure) with respect to whether we have made progress and/or delivered improvements. They are listed below:

Reduced and/or maintained % ALC	Suggests that patients are being well managed in community or LTC setting (particularly the 1-10% "high users"); that primary care is playing an integral role in the overall management of the patient's health care journey; that restorative care is appropriately available and effective (CSR) and that the tools enabling various providers to work together so closely such as IM have been implemented and are effective.
Reduced ED Wait Times for admitted patients and maintained for non-admitted patients	Suggests that hospital resources are being used effectively and jointly to support patients actually requiring hospital level intervention/care; that there are close linkages with community providers and primary care to enable appropriate and quick movement back into preferred community settings, etc.
Reduced # of CTAS 4 and 5 in ED (less urgent cases that could be seen by primary care or avoided)	Suggests Health Links are working to enable appropriate and timely care for patients outside of hospital settings and that patients are supported and feel confident in the community.
Reduced rate of 30 day readmission for selected conditions (CMG) post an acute event – particularly for cardiac, pulmonary, diabetes, etc.	Health Links have developed/adopted standard care pathways/protocols/checklists to support patients in managing their chronic disease effectively and with confidence in partnership with hospitals and CCACs. All members of the care team, including the patient and, regardless of type of provider, have confidential access to patient information to inform the care plan along the patient's health care journey. Expect a related decrease in avoidable ED visits as well.
Reduced repeat unscheduled visits to the ED for mental health & addictions	Suggests Health Links are working to enable appropriate and timely care for patients outside of hospital settings and that patients are supported and feel confident in the community. In addition, see reduced rate of 30 day readmissions.

Increased acuity in LTC Homes and receiving CCAC services	Suggests that patients are being managed effectively in the home at increasing levels of complexity both improving patient satisfaction and ensuring that that all providers in our system are working to the maximum of their scope.
Increased % of total funding spent on direct client care	Suggests that we have achieved a regional system of integrated care with reduced points of transition for patients with a focus on ensuring high users' needs are effectively and efficiently met.
% progress towards completion of French services Joint Action Plan	Suggests that we are successfully working with Francophones in the region to make our health care system more linguistically and culturally accessible for them, and also that we are making actual services more accessible
4 Indigenous Council Visioning Circles per year to build the relationship (one for on reserve, Metis and off reserve populations and one joint circle)	Indicates that our stated goal of engaging with Aboriginal and Metis communities has in fact happened
Development of a joint workplan to identify and quantify Aboriginal health care needs together with proposed initiatives to address those needs, and implementation of at least one of those programs	Suggests that we have been able to build a stronger relationship with Aboriginal and Metis communities, one that has yielded not only a solid work plan but also actual tangible results

CONCLUSION

An elderly patient, suffering from dementia and congestive heart failure becomes confused, suffers a fall and breaks her hip. She goes to the Emergency Room and waits for a bed to become available so she can have her hip repaired. The anaesthetic increases her level of confusion, and in attempting to communicate her frustration she becomes loud and is identified as being difficult to manage. Today that patient would face the very real prospect of spending weeks or months in that hospital bed, and the likely destination of a long term care home, simply because the system as it is today cannot support her in returning home.

We are changing that with our providers. Three years from now, that patient will have an advanced care plan that states she wishes to remain in her home as long as possible. Her primary care provider will be immediately notified of her admission, able to work with the hospital to ensure they are familiar with her case, and be prepared to follow up with the patient as soon as she is discharged. The CCAC will begin planning for her return home upon entry to the hospital with her circle of care providers. All participants in her care, from the hospital to the CCAC to her primary care provider, will have received training on working with people with challenging behaviours and will recognize that these are attempts at communication and be better able to manage the underlying issues. This patient will go home, with the supports in place that she needs, within the average length of stay for a patient with a hip fracture. And that is how health care is supposed to work.

Better Integration, Better Health Care is a plan informed by the clear understanding that in order to improve our current health care system; we have to improve the way it functions. We don't have to increase its size, or completely disassemble it then try to put it back together. What we must do, though, is search out every opportunity we can to make the system work better with the resources and expertise we already have at hand. And that is what we mean by integration.

For this integration plan to succeed over the next three years, we are going to need three things:

Collaborative Governance

When we talk about collaborative governance, we are talking about health care provider leaders who have a clear and consistent picture of the current state of health care strategies, provincially and regionally, understand the specific strategic direction of this IHSP3, and are committed to assisting in its implementation. We will need this from our health leaders in the years to come.

Commitment from Providers

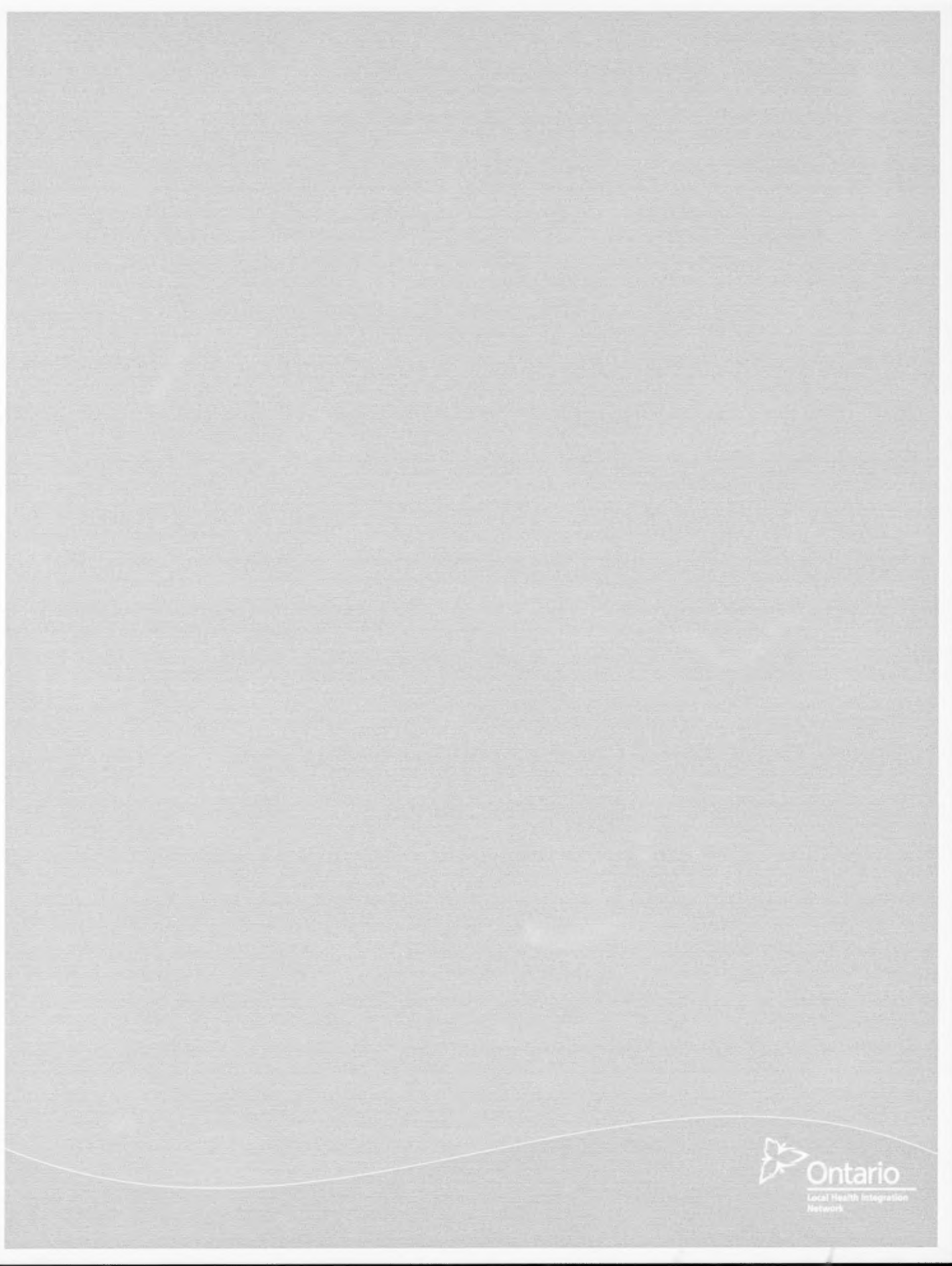
Integration cannot happen without providers, because by and large they are the people who will make integration happen. They are the people who will be sharing information and best practices. They are the people who will be organizing into networks. They are the people, at the end of the day, to whom we all look for health care. Our LHIN will spend the next three years working with providers to support their integration efforts in every way we can.

Patient Ownership

Better health care doesn't just come from providers. Patients have a huge role to play, and that role will only get bigger as we shift more care from acute settings out into our homes and communities. We need patients working harder at managing their chronic diseases. We need people giving more thought to healthier lifestyles, better diet, and fewer harmful habits. We need them, in other words, to own their health.

If this IHSP fulfills its promise and realizes its ambitions, then in the years to come, patients seeking treatment will be able to enter the healthcare system and get the most appropriate, focused, health care that's right for them, right away. They will be able to move from one part of a hospital to another, from one hospital to another, from the hospital into some form of community-based care, with the confidence that their providers have their best interests in mind; the system knows they are there, and they are going to receive the care they need.

All of these things are possible. And they can be accomplished without having to devour more money or impose new hardship. They require intelligence, commitment, compassion and skill – all things that we have in abundance in our health care system. They also require integration, which is what this plan is all about.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